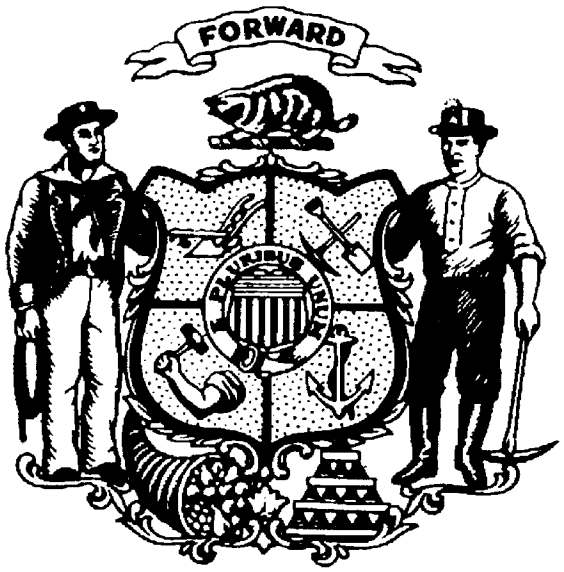
Governor's Task Force
On
Small Employer Health Insurance

Final Report
July 2001



Executive Summary

In the face of double digit annual increases in group health insurance premium rates in the small employer health insurance market former Governor Tommy G. Thompson created a task force in October of 2000 to look into the causes and craft recommendations that would assist small employers. Governor Scott McCallum supported the creation of the task force and encouraged its efforts when he assumed the Governor's office in February of 2001.

Insurance Commissioner Connie L. O'Connell was named chairperson of the task force with the responsibility of appointing the task force members, identifying the issues and guiding the efforts of the task force.

The task force held five meetings during which it examined the current state of the small employer health insurance market. The task force considered small groups as having 2 to 50 employees, as defined in Wisconsin law. The members considered current challenges faced by small employers in finding access to affordable health insurance, factors contributing to rising health insurance premiums, existing Wisconsin programs designed to assist small employers, efforts by other states to address the problem and possible changes to Wisconsin laws and regulations.

The Task Force was provided informational presentations on various subjects. The task force then identified options for consideration as sources of possible recommendations for the Governor. The Task Force operated on a consensus basis, only forwarding recommendations for which there were no objections. Ten recommendations were advanced. Three recommendations address insurance mandate studies and legislative consideration of small employer issues when proposing future mandates. Three recommendations are directed at increasing federal Medicare funding for Wisconsin in order to reduce the cost shifting that currently results in higher health care costs in the insurance market. Three recommendations address reform to the small group health insurance application process by creating a voluntary uniform application for small employers and requiring

insurers to request additional information and make final offers of coverage within certain time frames. Finally, the task force recommends that OCI increase its education and outreach efforts to small employers.

Small Employer Health Insurance Task Force Report

I. Problem

During the years 1999 and 2000, small employers began to see double-digit increases in premium rates for their group health insurance plans. In addition, a number of insurers reduced the geographic areas in which they operated in order to address financial losses. The combination of these factors created a significant challenge for many small employers seeking access to affordable health insurance.

On October 12, 2000, Governor Tommy Thompson announced the formation of a task force to address the affordability and availability of health insurance for smaller employers. Complaints filed with the Office of the Commissioner of Insurance regarding large premium increases and industry surveys documented the breadth of the problem. In 2000, OCI received 147 written complaints regarding group health insurance premiums. Additional predictions for double-digit premium increases in 2001 meant that affordability problems for some small employers were likely to continue.

Insurance Commissioner Connie L. O'Connell was charged with appointing task force members and identifying issues. The task force was asked to identify potential solutions to the problems of affordability and availability of health insurance for small employers in the state.

II. Mission

The mission of the Small Employer Health Insurance Task Force was to work as a team to identify and evaluate the challenges that small employers, and insurers, face while attempting to deliver affordable health insurance to the small employer workforce. The task force in reporting on its findings is making recommendations to Governor McCallum to help define the role that the State of Wisconsin can play in facilitating the availability of health insurance to the

employees of small businesses. To accomplish this mission the task force has solicited input from small employers, insurance industry representatives, health care providers, policy makers, and citizens.

III. Members

Commissioner O'Connell appointed the following individuals, representing insurers, agents, providers, small employers, and the Legislature to the task force:

- Timothy Bireley, President of Humana - Milwaukee
- Roger Breske, Democratic State Senator - Eland
- Steven Broeckert, Vice-President of Midwest Security Life Insurance Co.- Onalaska
- Don Carrig, co-owner of C&H, Inc - Reedsburg
- Paul Corcoran, co-owner of Corcoran Health Care - Richland Center
- Joe Decker, Vice President of Blue Cross Blue Shield United of Wisconsin - Milwaukee
- Paul Dell Uomo, President of Covenant Healthcare System, Inc. - Milwaukee
- Jeffrey Mason, Independent insurance agent - Ft. Atkinson
- Nancy Potter, former owner of New Glarus Bakery - New Glarus
- Lorraine Seratti, Republican Assemblywoman - Spread Eagle

Mr. Bireley was replaced at the March 2001 meeting by Mr. Bill Felsing, President and CEO of UnitedHealthcare in Milwaukee.

IV. Activities of the task force.

The task force held a series of meetings beginning in November 2000. The November meeting included a presentation by representatives of the Employer Health Care Alliance Cooperative (the Alliance) who gave a history of the Alliance-Chamber Health Insurance Program (A-CHIP). This program was intended to provide participating area Chambers of Commerce members with

access to multiple health plans with comprehensive benefits. By pooling employers under a larger group plan A-CHIP had intended to provide rate stability, competitive premiums, consistent underwriting standards and health coverage choice for small employers. Group Health Cooperative (GHC) of South Central Wisconsin of Madison, agreed to meet the program criteria of the A-CHIP plan, which included modifications to GHC's underwriting requirements and certain rate guarantees. A-CHIP began in Dane County in late 1996 and expanded into Green and Jefferson Counties in 1997.

In 2000, GHC began to experience significant losses as a result of higher than expected health care costs and utilization. In order to focus on its original core business in Dane County and to reduce losses, GHC determined to no longer provide coverage in Green and Jefferson counties.

The task force was given a briefing by OCI staff regarding the financial condition of the Wisconsin HMO industry. OCI distributed information showing that HMOs lost $58 million in 1999 and premium increases were at or below the rate of medical cost increases in every year between 1992 and 1999. OCI staff also presented the task force with reports that illustrated insurance industry rate changes for small employers from 1993 through 1999 as well as market share ranks among the health insurers providing coverage to Wisconsin employers, and a description of the regulatory relationship between OCI and health insurers. The referenced materials and data are included in Exhibits A, D and E at the end of this report.

The task force was also briefed on the Private Employer Health Care Coverage Program (PEHCCP). Created by 1999 Wisconsin Act 9, PEHCCP was designed to provide group health insurance statewide. As designed, the program would find a commercial administrator to administer the plan. The administrator would contract with insurers who would provide benefits to employers enrolled in the plan. Staff in the Office of Private Employer Health Care Coverage Program told the task force that the primary goal of PEHCCP was to offer a choice of health plans to employers enrolled in their program. PEHCCP staff acknowledged that

the cost of PEHCCP coverage could be seven to eight percent higher than in the existing private market, as has been the experience in California. The administrator was charged with contracting with insurers across the state to provide multiple benefit options, similar to the State of Wisconsin's employee health benefit plan administered by the Department of Employee Trust Funds. Act 9 set a target date of January 1, 2001, as the date the program was to begin.

At the conclusion of the November 2000 meeting Commissioner O'Connell solicited suggestions from the task force members for further study and to formulate recommendations. The task force members volunteered 28 different subjects they wanted to examine further. These subjects were further refined into common suggestions for research:

A. Coverage and provider mandates on health insurance policies
B. Provider cost containment mechanisms
C. Health care costs in Wisconsin/Health care cost survey
D. BadgerCare/Health Insurance Premium Payment Program
E. Other states' attempts at health insurance reforms
F. Tax incentives
G. Medicare provider reimbursements
H. Application process for small employers
I. Small employer premium rating
J. The Wisconsin Health Insurance Risk Sharing Program
K. Education and outreach for small employers

Detailed agendas, meeting materials, and meeting minutes are available from the OCI website at: http://badger.state.wi.us/agencies/oci/sm_emp.htm

V. Suggestions for Research

A. Mandated Benefits

The task force was briefed on current requirements for mandated benefits and provider coverage. Mandated benefits are required by the state and federal governments to provide coverage for specific treatments or illnesses; services performed by certain types of providers, or health insurance coverage of certain groups of people, such as adopted or handicapped children. The briefing described the current number of mandates that exist in Wisconsin and reviewed the results of a previous mandate study that was done in Wisconsin in 1990 with a follow up study completed in 1991. These studies determined the cost of the mandates surveyed ranged between 5.7 to 7.5 percent of premium cost between 1987 and 1990. Information was also provided for more recent mandate studies conducted in other states. Generally, mandated benefits were found to contribute between 5% to 15% of the premium cost. However, when one state (Maryland) made an estimation of the marginal cost of mandates, or the additional cost to those insurers that were not already providing the mandated benefit, the cost of the mandate dropped to 3.9%. It was noted that since mandate statutes differ throughout the states and that some of the mandate studies (including Wisconsin's) did not measure all of the mandates, these figures were only valid for general comparisons.

The task force was also briefed on the existence of mandate-free or limited mandate plans in other states and Wisconsin's previous effort at creating a Basic Benefit Plan that modified, but did not eliminate one of the existing mandated benefits (mental health and substance abuse).

B. Cost Containment Commission

The task force was given a briefing on the Cost Containment Commission, which existed from 1993 to 1995. The Commission was charged with reviewing the cost effectiveness of capital expenditures for buildings and equipment for hospitals and other health care providers. The Commission also approved the formation of new home health agencies in the state.

By statute, 12 review criteria for a capital expenditure greater than $1 million had to be met, before the Commission could approve a project. During its two years of existence, the Commission did disapprove several projects.

However, the Commission existed during a time of low health care inflation, resulting in little public support for its work. In addition, there was an 18-month lag between the passage of the legislation authorizing the Commission and its effective date, allowing for commitments to many capital expenditure projects exempt from Commission review.

The Commission sunset with passage of the 1995-97 state budget.

C. Health Care Cost Survey

The task force was briefed on the results of a health care cost survey conducted by OCI staff (Exhibit B). The survey asked insurers to examine what factors contributed to increased health insurance claim costs from a base year of October 1998 to September 1999 compared to October 1999 to September 2000. The survey considered increased costs for prescription drugs, physician services, hospital, outpatient mental health and all other. The cost increases were attributed to both higher costs per service as well as increased utilization of services. The highest rate of increase was for prescription drug costs. From the base year, total claim costs for prescription drugs increased by 18.4%. All physician services increased by 12.8%. Total hospital costs increased by 10.9%. The only health care service with a decrease in costs was outpatient mental health services with a decrease of 9.4%. Other miscellaneous costs increased 11.6%.

Finally, OCI staff relayed information from a Hewitt Health Value Initiative study that reflected per capita health care costs across the nation (Exhibit C). The study revealed that Wisconsin, and the Milwaukee and Madison

areas in particular, have some of the highest per capita health care costs in the country, surpassing New York City, Boston, and Washington, DC.

Double-digit increases in health care costs and utilization directly impact the premiums that must be charged by insurers. Task force members expressed some frustration that because they are unable to affect medical inflation, they would not be able to affect premium increases, and thus they would not be able to make meaningful recommendations to the Governor.

D. BadgerCare/HIPP

The task force was presented information on BadgerCare, a state-sponsored health insurance program designed to assist individuals in transitioning into the workforce. Uninsured families with incomes below 185% of the federal poverty level, who are not eligible for Medicaid are eligible for BadgerCare. There is no asset test in determining eligibility.

BadgerCare is operated as an expansion of the state's Medicaid program and the Children's Health Insurance Program (CHIP). The federal Department of Health and Human Services (DHHS) has approved a waiver of some Medicaid and CHIP program eligibility requirements in order to allow the program to operate in Wisconsin.

A specific requirement of the waiver is that the state takes steps to ensure that BadgerCare does not replace health insurance available in the private market. Many of BadgerCare's eligibility requirements are designed to ensure that enrollees are not supplanting otherwise available private health insurance with BadgerCare.

Both the state and federal government subsidize BadgerCare. Any expansion of the program would require an additional federal waiver as well as additional budget authority from the state.

The HIPP (Health Insurance Premium Payment) program helps eligible families receive health insurance through qualified employer sponsored health insurance plans. HIPP is also a part of BadgerCare and allows the state to reimburse employers for the employee share of health insurance premiums.

E. Other State Insurance Reforms

The task force examined reforms undertaken by other states. Following the failure to adopt, on a national level, broad-based health care reform, many states initiated their own reform efforts. The focus of these reforms was reducing the number of uninsured. The reforms have primarily taken three forms: comprehensive broad benefit packages, purchasing alliances, and limited benefit or "mandate-free" packages.

The State of Washington created a uniform comprehensive benefits package that was mandated on all citizens who were not a part of a self-insured plan. Everyone was required to purchase a mandatory managed care plan that capped premium increases to the growth in personal income. After one year, many insurers began leaving the market and the amount of uninsured actually increased due to the guaranteed issue provisions of the plan and the resulting premium increases. The reforms were repealed 18 months after implementation.

TennCare in Tennessee offered a comprehensive benefits package that covered 25% of its population. There were limits placed on who could participate, mainly those eligible for Medicaid, uninsured children, displaced workers, high-risk uninsurable people, and low-income adults. This lead to adverse selection and skyrocketing costs. TennCare today takes up $4.3 billion dollars of the state budget and has caused discussion of implementing an income tax in Tennessee. Some insurers have left the market, including Blue Cross/Blue Shield, who announced they would leave the market at the end of 2000. Blue Cross/Blue Shield served 50% of the TennCare market.

The most common type of reform attempted by states was the creation of purchasing alliances or pools. The idea behind purchasing alliances has been to allow small employers to band together to facilitate choice in health plans, a single point of entry, and leveraged buying power. The results have been mixed. Some states, such as California, which historically has one of the highest uninsured rates in the nation, have indicated their plans have been successful measured by high enrollment and a decrease in the uninsured population. Other states such as Texas and North Carolina have not been successful and their purchasing pool legislation has been repealed. Because the rates vary more widely in the small employer market, small employer pools are much more susceptible to attracting more expensive groups while lower cost groups obtain cheaper coverage outside the pool. This result, known as adverse selection, has plagued many of the attempted pooling arrangements. Adverse selection is the cause of what is known as a death spiral of increasing costs within a pool until only the most unhealthy groups are left.

Maryland, New Jersey and New York have implemented standard benefit health plans that offer “streamlined” health packages for small employers. Maryland has had their plan in place since 1995, New Jersey since 1994, while New York’s Healthy Pass plan became effective on January 1, 2001. These plans are similarly structured in that they create a minimum benefit level that all plans (all HMO’s in the case of New York) must offer. Additional coverages can be obtained from insurers in the form of riders.

While the reforms by Maryland, New Jersey and New York are said to be mandate-free policies, that is not an entirely accurate representation. Maryland, for instance, still has 12 of their 36 mandates in their basic package. With the ability to add riders taken into account, the plans appear to offer flexibility and choice to small employers. Maryland’s restriction on costs has kept premium increases at a flexible level. All of the states that have basic benefit packages mandate some form of rate

control for insurers who offer coverage to small employers. Maryland's plan, for example, limits premiums to 12% of the average annual income in the state. Maryland has maintained an enrollment of between 450,000 and 500,000 covered lives since the inception of their small employer plan.

New Jersey's basic benefit package is not mandatory, as was originally intended, but must be offered. The plan competes with other non-standard plans. There were 779,000 people enrolled in small employer plans as of 1996 with 56% being enrolled in the basic benefits plan. New Jersey also noticed an increase of 15% in the enrollment of small employers in 1995.

It is uncertain how these plans will fare in the current environment where medical inflation is driving up premiums. In Maryland, where the 12% cap divorces premium setting from actual medical costs, the program's premiums are approaching the cap and health plan officials are assessing their options.

F. Tax Incentives

Tax incentives are popular mechanisms for encouraging the purchase of health insurance. While employers generally get a 100% deduction for the health insurance premiums that they pay for their employees, employees do not receive as favorable a tax treatment for any additional premium, co-payment, or deductible they pay. Federal law permits as itemized deductions amounts paid by individuals for health insurance premiums, medical expenses, prescription drugs, and other miscellaneous medical related expenses. However, medical deductions must be reduced by 7.5% of adjusted gross income. The remainder may be claimed as an itemized deduction on Federal Schedule A. Most Americans cannot take advantage of this deduction. Almost every state has introduced legislation that has some sort of tax credit or deduction for

health insurance premiums paid by individuals or small employers. Most states have found these proposals to be cost prohibitive and very few have been enacted into law. A recent fiscal estimate by the Wisconsin Department of Revenue for 2001 Assembly Bill 282, that would make all health insurance premiums, medical cost and other medical expenses tax deductible, estimated that the health insurance premium portion alone would cost the State of Wisconsin $104 million in tax revenues.

G. Medicare Cost Reimbursement Inequities

The Medicare reimbursement system for hospital, physicians, and HMOs uses a thirty-year-old formula that is based on regional historical health care costs. When the formula was established, health care delivery in the Midwest cost less than in other areas of the country. Today, the opposite is true. Health care costs in the Midwest, and Wisconsin in particular, are some of the highest in the nation. Yet the reimbursement mechanism does not reflect this change. For example, Wisconsin receives 88% of its Medicare costs reimbursed while New York receives 102%. The Balanced Budget Act of 1997 aggravated the problem by limiting the growth in Medicare reimbursements.

According to the Wisconsin Health and Hospital Association, in 1998 the Medicare program underfunded Wisconsin hospitals by $320 million per year (Exhibit F). When physician reimbursements are included, the shortfall estimates reach $1 billion annually.

The task force considered the impact this underfunding has on the availability of private health insurance. Providers explained that unfunded costs of Medicare recipients were made up by shifting costs, resulting in higher charges for insured patients. Therefore, the ultimate impact is higher premiums for private health insurance policies.

H. Application Process Reform

Employer members of the task force raised concerns about the health insurance application process. Small employers, not having full-time human resource personnel, have found it burdensome and time consuming when shopping for health insurance coverage, to fill out multiple applications, not to mention pulling employees off of production lines to fill out multiple medical questionnaires.

Employers are also concerned with the up-front deposit, usually the first month's premium, which is required by some insurers to obtain a final offer of coverage. When small employers are completing multiple applications for different insurers, the resources required can become cost prohibitive for the small employer.

Another concern raised by small employers is the length of time it takes to obtain a final offer of coverage from some insurers following the receipt of a completed application for coverage. Some speculated that insurers may delay rate quotes in order to avoid making final offers to groups, usually high-risk groups, they do not want to insure. Coverage of work-related injuries was another concern. Employers were sometimes surprised to learn that coverage of work-related injuries was not included in their health plans.

I. Small Employer Premium Rating

Wisconsin laws relating to health insurance premium increases were examined. Under current law, rates for small employer groups cannot vary more than 30% from the midpoint rate for groups with the same benefits and case characteristics. Further, insurers must limit the portion of the rate increase that is due to health status or claims experience to 15%. Discussion focused on the advisability of further limiting insurer's ability to increase premiums.

UnitedHealthcare, Inc. President and CEO William Felsing presented several examples of how the current laws work with groups with various characteristics.

Questions were raised regarding the advisability of additional limitations on an insurer's ability to increase premiums. For example, if insurers were further restricted in their ability to set premiums, high-risk groups would have premium increases limited. However, lower risk-groups would likely pay higher premiums, causing some of them to drop coverage, which would leave relatively higher risk to be spread across a smaller number of groups. In addition, rate band restrictions may affect the financial stability of insurers, prompting some to withdraw from the market entirely. This would negatively impact the accessibility of health insurance for small employers.

In the alternative, if insurers were given greater flexibility to increase premiums based on actual experience or health status, low risk groups would pay less but high-risk groups would pay even higher premiums.

J. Health Insurance Risk Sharing Program (HIRSP)

HIRSP is the state-sponsored health insurance program for those individuals who are unable to obtain insurance in the private market due to health conditions. It functions to address market dislocations in the individual health insurance market by making an affordable, but more expensive than the private market, health insurance policy available.

HIRSP is funded through a combination of state funding, policyholder premiums, and assessments on insurance companies and provider discounts. Enrollment in HIRSP has increased sharply during the last year, placing a larger burden to support the program on providers and insurers, again requiring cost shifting to small employers through higher medical costs and insurance premiums.

K. Education and Outreach

Wisconsin has a strong economic interest in the success of small businesses. Recent statistics from the Department of Workforce Development (DWD) suggest that approximately 20% of state residents are employed by small businesses. Managers of small businesses need to deal with complex issues such as business plans, accounting systems, payroll processes, employee recruitment, cash flow problems, marketing, and risk management. They often have few resources available to them to deal with these complicated issues, and often do not know whom to contact when they have questions. Lack of resources causes a significant portion of small businesses to fail in their first few years.

In order to attract employees, small employers try to offer competitive salaries and benefits. Small businesses have found it increasingly more difficult to obtain affordable health insurance for themselves and their employees. Some small employers have seen premium increases over 50% in the past year.

Small businesses have to deal with a large array of insurance needs such as business owner's policies, auto insurance, Worker's Compensation, property and casualty insurance, liability insurance, flood insurance, health insurance, and life insurance. Larger companies often have full-time staff dedicated to these functions; the time needed to investigate each of these concerns is considerable.

Small employers have a difficult time locating information for insurance of every type of coverage, not just health insurance. Employers also have little time to spend on insurance matters. Given the current economic environment, recruiting and retaining employees in an extremely tight labor force means they need access to information quickly. OCI publishes a number of brochures including one directed specifically to the small employer.

VI. Task Force Recommendations

The task force reached consensus on the following recommendations:

A. ***Health Insurance Coverage and Provider Mandates.*** The task force acknowledges that mandated benefits add to the cost of health insurance. Studies have shown mandates may add up to 15% to premiums. Future mandates could make health insurance even less affordable. The task force recommends:

a.) OCI conduct a study of the cost of selected health insurance mandates. The Legislature will be asked to evaluate the impact of existing mandates based on the OCI study, including eliminating mandates or requiring insurers to offer coverage instead of requiring coverage for specified benefits, groups and providers,

b.) The Legislature give serious consideration to the financial impact on small employers of additional mandates, and

c.) The Legislature give serious consideration to limiting new mandates to employers with more than 50 employees, therefore exempting small group insurance.

B. ***Medicare Reimbursement Inequities.*** The task force adopted three recommendations:

a.) Petition President Bush, Health and Human Services Secretary Thompson, and Wisconsin's congressional delegation to make changes to the Medicare program that will eliminate the reimbursement inequities faced by Wisconsin hospitals, physicians, and HMOs.

b.) Form a coalition of midwestern states that will also work to eliminate the reimbursement inequities.

c.) Convene a Medicare Reimbursement Inequity Summit, co-sponsored by Medicare stakeholders that share a common goal of reducing the reimbursement inequities. A coalition of hospitals, physicians, employers, insurers, and government could more closely examine the issues

connected with Medicare provider reimbursements, heighten public awareness, and formulate a unified approach to petition the federal government for equity in Medicare reimbursements.

C. ***Group Insurance Uniform Application.*** The task force has three recommendations for the governor:

a.) OCI shall organize a work group consisting of health insurers in Wisconsin to develop a voluntary uniform application for small employers. The group should also examine the merits of making a uniform application voluntary or mandatory for all insurers.

b.) Require insurers to provide a final offer for group coverage within 15 working days of receiving a completed application and other information necessary to provide the offer of coverage.

c.) Require insurers to notify an employer within 15 working days of receiving an application for coverage of any additional information that is needed by the insurer to provide the offer of coverage. Insurers not meeting this requirement would be required to advise the applicant of the maximum rate possible within the 15-day period.

D. ***OCI Education and Outreach***

Increase OCI education and outreach efforts to small employers. This effort could include gathering data on subjects such as health insurance cost data. This information would be shared with small employers to assist them in identifying factors contributing to health insurance cost increases. Other information, such as making employers aware that some health insurance policies do not provide coverage for work-related injuries, should be regularly provided to insurance consumers in order to create a more informed insurance customer. Also, speaking to business groups and developing and maintaining brochures that address the needs of small businesses. With the advent of the Internet, businesses increasingly expect to have information available to them 24 hours a day, 7 days a week. To address this, OCI

should create and maintain an Internet site devoted to small business insurance.

Exhibit A

Small Employers Rate Change - 1999

(January 2, 1999 - January 1, 2000)

Company Name	All Business		Open Blocks		Closed Blocks	
	Premium	Rate Chg	Premium	Rate Chg	Premium	Rate Chg
Aetna	4,100,976	13.7%	4,100,976	13.7%		
Alta HP (fka Anthem Life)	783,584	5.0%	783,584	5.0%		
Atrium HP	6,422,614	9.8%	6,422,614	9.8%		
Blue Cross	77,722,626	11.1%	77,722,626	11.1%		
Central Benefits Natl	6,203,055	7.7%	6,203,055	7.7%		
Centris Life (fka Seaboard Life)	26,537	7.7%			26,537	7.7%
Compcare	46,296,000	8.0%	46,296,000	8.0%		
Consec Medical(fka Conn Nat'l Life)	2,510,757	20.0%	519,376	9.8%	1,991,381	22.7%
Dean Health Plan	9,742,302	22.9%	1,285,619	25.3%	8,456,683	22.5%
Emphesys	39,525,835	25.3%	39,525,835	25.3%		
Employers Health	89,570,644	27.3%	89,570,644	27.3%		
Employers Ins of Wausau	14,240,497	21.9%	14,128,449	21.8%	112,048	34.4%
Epic	1,175,516	9.9%	1,175,516	9.9%		
Family Health Plan	17,438,363	8.0%	17,438,363	8.0%		
Federated Mutual	14,318,389	18.4%	14,318,389	18.4%		
First Allmerica - new	1,685,004	41.5%	1,685,004	41.5%		
Fortis Benefits Ins Co	4,471,735	22.3%	4,333,490	22.3%	138,245	22.3%
Fortis Ins (fka Time)	15,522,738	18.1%	7,272,980	18.1%	8,249,758	18.1%
)lden Rule	2,899,167	17.1%	2,010,520	17.0%	888,647	17.3%
Great Midwest Ins	643,559	22.5%	643,559	22.5%		
Greater LaCrosse	6,174,587	9.5%	6,174,587	9.5%		
Group Health - EC	58,393	10.5%	58,393	10.5%		
Group Health - SC	13,138,740	8.0%	13,138,740	8.0%		
Guardian Life	6,172,637	24.1%	6,172,637	24.1%		
Gunderson Lutheran	1,763,314	10.5%	1,763,314	10.5%		
Humana Wisc Health	7,136,014	13.1%	7,136,014	13.1%		
John Alden Life	10,252,136	38.8%	10,125,683	39.1%	126,453	16.1%
John Hancock	1,701,716	19.4%	1,697,263	19.4%	4,453	15.0%
Life Investors	1,038,981	17.4%	1,038,981	17.4%		
Medica HP	2,137,510	9.8%	2,137,510	9.8%		
Medica Insurance	1,925,655	9.8%	1,925,655	9.8%		
Medical Associates	991,239	15.2%	991,239	15.2%		
Mega Life & Health	772,345	42.5%	741,328	42.9%	31,017	33.2%
Metroplitan Life	257,101	11.3%			257,101	11.3%
MercyCare(fka MHS)	5,787,093	18.3%	3,411,696	9.0%	2,375,397	31.7%
Midwest Security Life	36,655,515	19.9%	36,369,323	20.0%	286,192	12.3%
Midwestern United Life	784,151	0.0%	784,151	0.0%		
National Health Ins	4,344	0.0%			4,344	0.0%
Network Health Plan	39,128,711	8.7%	38,745,680	8.7%	383,031	8.1%
New England Life	986,792	11.3%	986,792	11.3%		
New York Life Ins(NYLCARE)	27,990	0.4%	27,990	0.4%		
North Central HPP	10,950,685	12.6%	10,950,685	12.6%		

Exhibit A

Small Employers Rate Change - 1999

(January 2, 1999 - January 1, 2000)

Company Name	All Business		Open Blocks		Closed Blocks	
	Premium	Rate Chg	Premium	Rate Chg	Premium	Rate Chg
Pacifc Life & Annuity	24,145	15.6%	24,145	15.6%		
Pekin Mut Life Ins	6,585,696	29.5%	6,390,750	29.6%	194,946	25.0%
PFL Life	185,563	17.9%			185,563	17.9%
Physicians Plus	54,621,252	21.3%	54,621,252	21.3%		
Pioneer Life	653,704	16.3%	351,500	13.2%	302,204	20.0%
Prevea HP	10,190,003	18.5%	10,190,003	18.5%		
Principal Life	40,451,221	24.3%	40,451,221	24.3%		
Prudential	14,163,742	8.9%	14,163,742	8.9%		
Sentry Life	1,994,298	26.8%	1,994,298	26.8%		
Sentry Select (fka John Deere)	1,332,270	20.7%	1,332,270	20.7%		
Touchpoint HP (fka United Health of Wi)	23,142,444	27.9%	23,142,444	27.9%		
Trustmark	6,632,314	10.0%	6,590,832	10.0%	41,482	10.6%
UnitedHealthCare of Wi (fka PrimeCare)	165,329,480	8.2%	165,329,480	8.2%		
United HealthCare Ins	21,478,490	6.2%	21,478,490	6.2%		
United of Omaha	556,035	0.0%	556,035	0.0%		
United Wisconsin Life	26,485,807	19.3%	26,485,807	19.3%		
United World Life	238,207	0.0%	238,207	0.0%		
Unity HP	29,629,143	7.0%	29,629,143	7.0%		
alley Health Plan	6,442,000	11.0%	6,442,000	11.0%		
Wausau Preferred	358,101	6.0%	358,101	6.0%	358,101	6.0%
Wellmark Comm	4,806,208	25.8%	4,806,208	25.8%		
Wisc Phys Serv	63,055,023	10.2%	60,527,688	10.3%	2,527,335	8.6%
Woodmen Acc & Life	67,002	23.1%	67,002	23.1%		
Totals	981,567,695	15.5%	954,559,775	15.3%	27,007,920	19.8%

Group Health Rate Increase Analysis

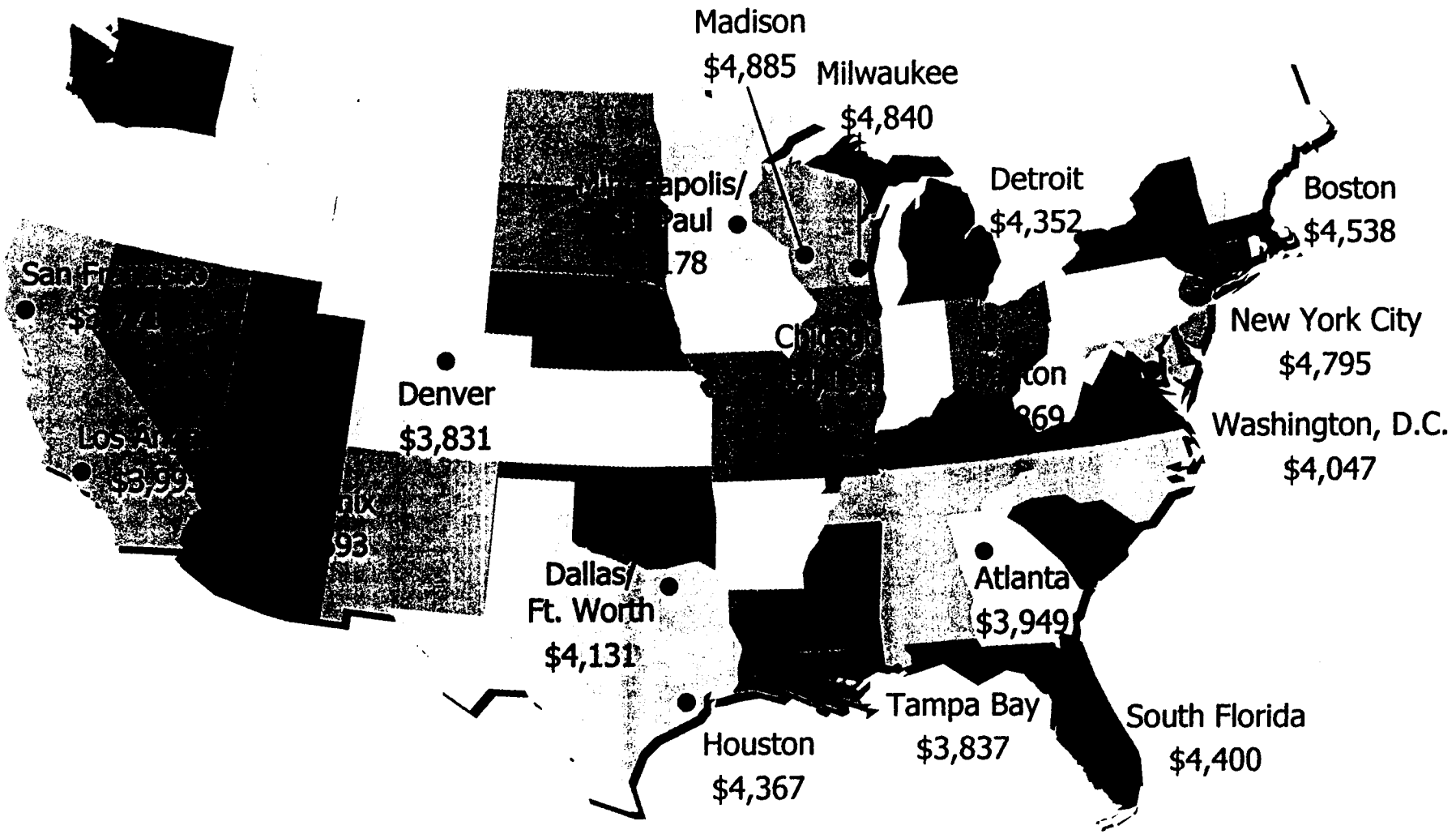
Exhibit B

Year 1: 10/98 - 9/99
Year 2: 10/99 - 9/00

Service	Percent Increase of Claims from Year 1 to Year 2						Contribution to Total Rise in Claims	
	Utilization		Cost per Service		Total Claim Costs			
Prescription Drugs	5.7%		11.9%		18.4%		21.3%	
All Physician Service	6.2%		6.2%		12.8%		42.1%	
Primary		6.1%		7.5%		14.1%		20.3%
Secondary		6.3%		5.6%		12.3%		21.8%
Total Hospital	4.0%		6.6%		10.9%		33.0%	
Inpatient		3.9%		8.3%		12.6%		16.0%
Outpatient		4.0%		9.2%		13.6%		17.0%
Outpatient Mental Health	-0.2%		-9.2%		-9.4%		-1.3%	
All Other	1.0%		10.5%		11.6%		4.8%	
Total					**12.3%**		**100.0%**	

Exhibit C

Medical Costs Top Average



Source: Milwaukee Journal Sentinel October 26, 2000
Hewitt Health Value Initiative™

Exhibit D

Year to Year Increases for Licensed Domestic HMOs

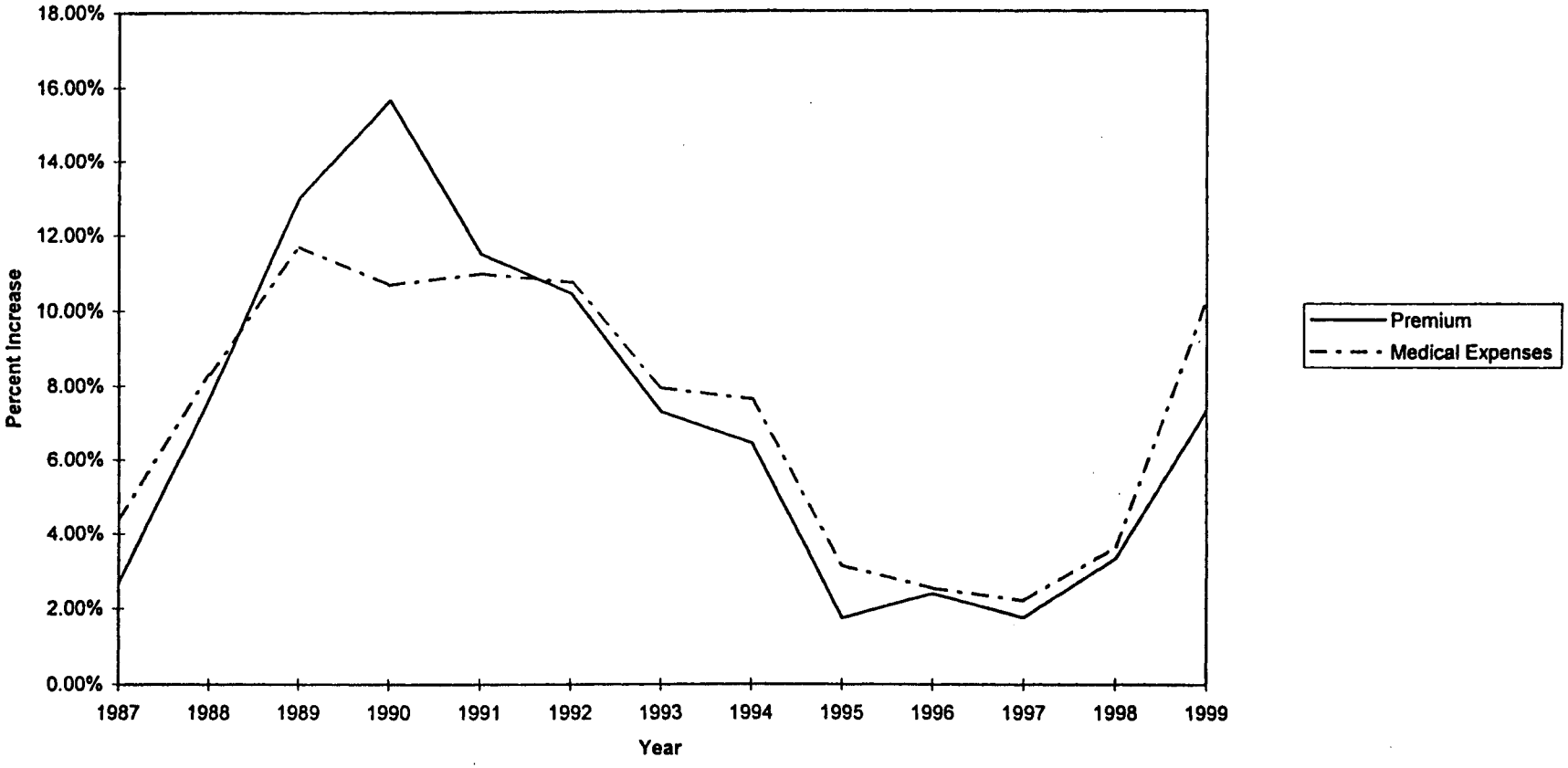


Exhibit E

HMO Net Income During the 90s

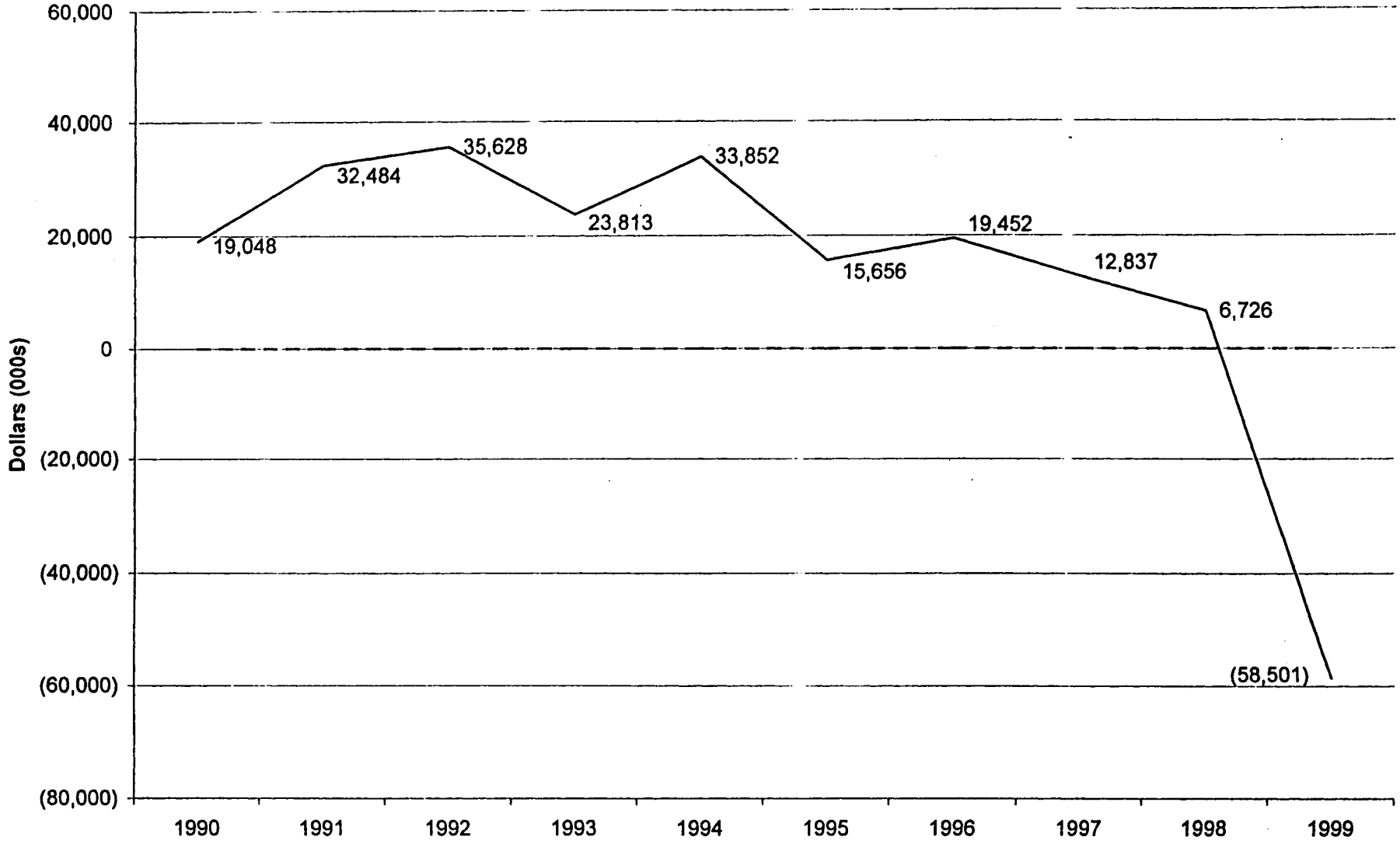
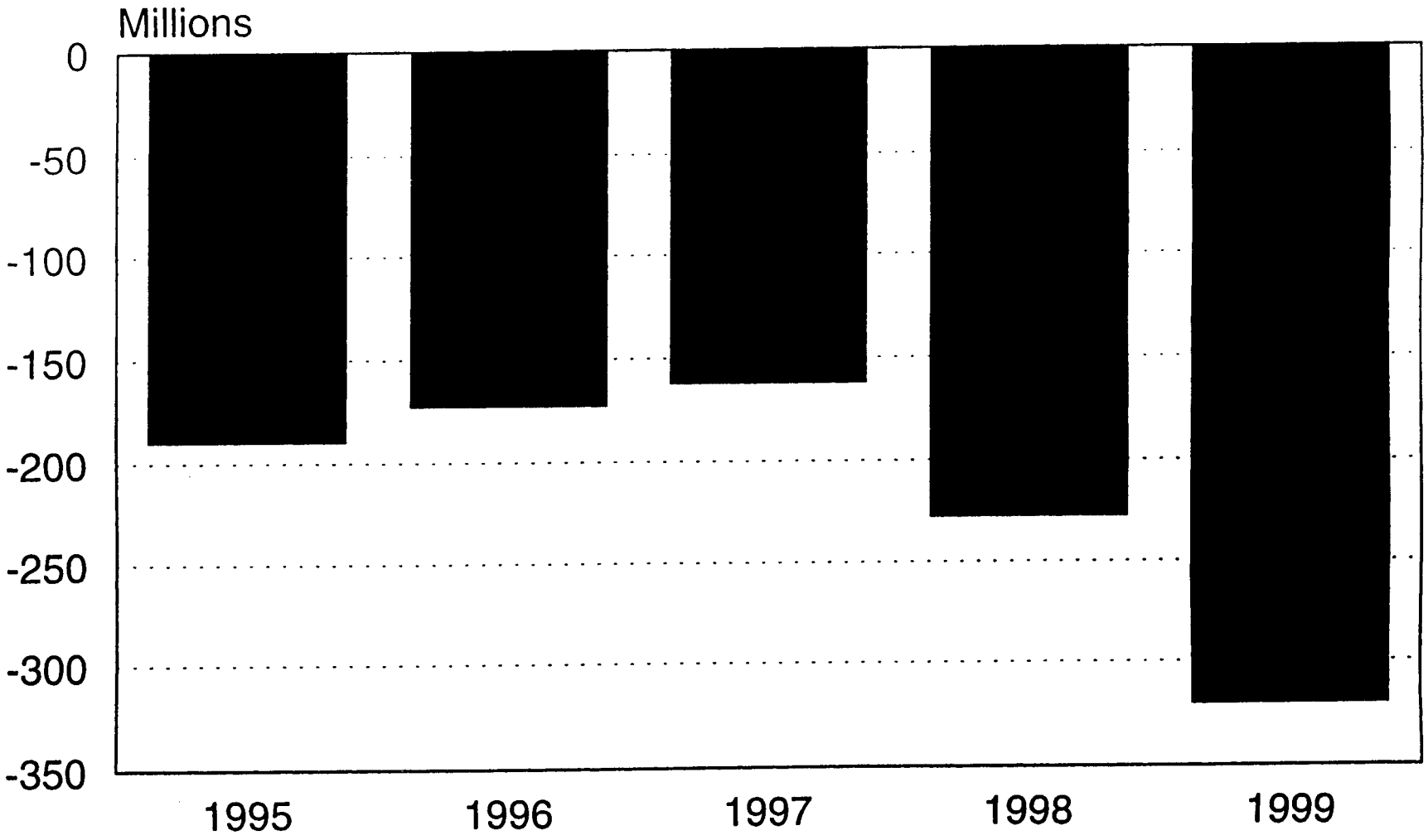


Exhibit F

Medicare Shortfalls in Payments

Wisconsin Hospitals



WHA estimate using BHI fiscal survey data